

DAY SUPPORT WAIVER

Supported Employment Individual Service Authorization Request

CSB _____

CSB provider # _____

Do NOT Use for MR Waiver

- ☐ Initiate Waiver services
- ☐ Service Modification
- ☐ Increase units/hours of service
- ☐ Decrease units/hours of service
- ☐ Procedure code modification (requires 2 ISARs)
- ☐ Provider modification (requires 2 ISARs)

Provider Name _____

Provider No. _____

Name: _____

Start: _____

End: _____

Last,

First

MI

Date

Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED
ONLY

WEEKLY / MONTHLY UNITS

OMR USE

☐ H2023 Supported Emp., Individual Placement_____
Units / week

x 4.6 =

Monthly Total☐ H2024 Supported Emp., Group_____
Units / week

x 4.6 =

Monthly Total

Reason for this request: _____

Check the allowable activities that are included in the ISP:

- ☐ Individualized assessment & development of employment related goals
- ☐ Individualized job development
- ☐ On-the-job training in work & work-related skills required to perform the job
- ☐ Ongoing evaluation, supervision and monitoring of job performance beyond supervisor's responsibilities
- ☐ Ongoing support services necessary to assure job retention
- ☐ Training in related skills essential to obtaining & retaining employment
- ☐ Travel with the individual to and from work sites, when other travel assistance unavailable
- ☐ Other: _____

There is documentation in the record that Supported Employment Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? ☐ Yes ☐ No

Record the number of hours per day of the following:

(for biweekly/ varied schedules, draw a line to indicate different weeks)

SUN

MON

TUES

WED

THU

FRI

SAT

Total Hours of Program Time

(e.g., if individual is in program from 8 a.m. until noon, enter "4")

Travel with the individual to & from program:*[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]*

Comments: _____

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) _____

Signature _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/Case Manager (print) _____

Signature _____

Phone No. _____

Fax No. _____

Date _____